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RAO BAHADUR Dr. C. B. RAMA RAO, B.A., M.D.

The Founder and the First President of the Union.

RAO BAHADUR Dr. C B RAMA RAO, B A., M D.

A Short Life Sketch.

"Dr Rama Rao's career illustrated the rise to eminence of a wholly self-made man" With these appropriate words Mr. J R Higgins, I C S, Collector of Tanjore began his speech in the year 1917 in the special Durbar that was held to confer the sanad of Rao Bahadur that was graciously bestowed on him by the British Government Nearly a quarter of a century has rolled by since then, and Dr C B Rama Rao is happily with us, an octagenarian, and a Nestor among medical men

Dr. Rama Rao is Mysorean by birth who brought credit to himself and to his State by his service in the Madras Presidency He was born in the year 1859. His father Mr C Subba Rao was a Jodidar of Colamaraka Cuppe, a village in the Bangalore District He had his early education in the Mission School, and later joined the Central College, Bangalore Before he graduated, he left the College to join the Madras Medical College in the year 1878. Again in the words of Mr Higgins, "In the days he studied medical science, there were not as many advantages for learning it as they had now Passing the Apothecary examination in 1882, he entered service" His first appointment was medical officer in charge of the Local Fund Dispensary, Periyakolam, Madura District In 1886 he was posted as the Resident Medical Officer of the Royapuram Hospital For short periods he was posted to Ranipet and Gooty, and then he was appointed as Assistant Professor in the Madras Medical College Need it be said that he was the first Indian medical officer to be admitted to the staff of the Madras Medical College

As in the case of many the possession of a diploma did not end his studies In service, in the midst of the discharge of his onerous duties, he studied privately and took the L M & S, and B.A degrees. In the College he taught and trained successive generations of medical students.

Before his further career is sketched, this is the right place to pause to think of what the past generation of students particularly in the George Town (then the Black Town) owe to him. The streets running parallel to one another opposite the High Court were the bee-hives of students All of them looked up to Dr C B Rama Rao, not merely as a medical man to cure the ailments, but as a true friend and correct guide. His name was on the lips of all of them, and his consulting room in Linga Chetty Street became more or less a shrine He was as popular among laymen as among students Dr U Rama Rao had his early tutelage under him

He did not confine his activities to his profession alone He took a good deal of interest in all social activities. To mention one the opening by

His Excellency the Governor of Madras of Dr. Varadappa Naidu's Orphanage for Hindu Children

When he had earned a holiday he spent it, not as most others would have spent it, at home and in ease; he undertook a tour round the world He went to Europe in 1906 for a further prosecution of his studies He studied at the Edinburgh University, took a special course of training at the Rotunda Hospital, and finally received the M D Degree at the Dublin University in 1907. As a delegate from South India he attended the British Medical Association Anniversary held in Toronto in Canada He travelled widely throughout the world, Japan, the United States, Canada and Europe

He gave evidence before the Royal Public Services Commission as the elected spokesman of the Provincial Medical Service He spoke strongly against the then prevailing system of recruitment and utilisation of Indians in the higher branches of the medical services

In 1912 he was promoted to the grade of Civil Surgeon and posted to Tellicherry In 1915 he was posted as acting District and Sanitary officer, and Superintendent of the Medical School, Tanjore, from where he retired in 1919. In this district he had been the means of opening several new dispensaries and strengthening the Medical School, whose claims he had persistently urged, and of providing suitable accommodation to its students by having a hostel built by *the Government on the land* they had acquired for the purpose. At the headquarters and in his tours through the District he called together widows whom he advised to take training under an organised system in the hospitals, and he made a beginning in Tanjore.

His activities as stated above are varied. He was nominated member of the first Reformed Legislative Council of Madras He ran a private charitable hospital for women and children from 1920 to 1922 He was a fellow of the Madras University for three years.

Since his retirement he has settled down in Bangalore City. A decade back there was not a public utility organisation in Bangalore, Government or public, in which he did not take a leading part. Rural reconstruction, uplift of the Harijans, Municipal *administration, Social welfare had all* their due share of devotion from him. A gentleman of sterling character, of punctilious loyalty to duty, of correct time sense, of abundant energy and selfless attachment, and with all a personification of gentleness and humility tempered with sternness, it is no wonder he is feared, loved and respected.

Prevention of Tuberculosis.

L. V. SRINIVASAN, M.B.B.S., MADRAS.

Inheritance

In the case of chronic diseases, such as tuberculosis, the organism, gains entrance into the bodies of the great majority of the population, but only a small percentage develop clinical tuberculosis. With a disease of such a long duration, it is very difficult to assess the relative importance of heredity and of the environmental factors, which undoubtedly play a part in its aetiology. Carefully collected and analysed data, however, show that an inherited susceptibility exists in some families. Those published by Von Vercheur and by Diehl on Tuberculosis in a hundred pairs of twins, are most valuable. It was found that in uniovular twins, both members of a pair developed disease far more often than in binovular twins, and this was true even when the environment of the pair had been different.

Constitution

Crew defines constitution as the sum of those chemical, immunological, physical, physiological, and psychological peculiarities exhibited by an individual in relation to his environment, or by different tissues or functions in relation to one another. However sound a man may be, his environment may be so unfavourable that he may break down physically, mentally or in his immunity to infection, but the man who has inherited a constitutional weakness is likely to break down under conditions which would not have any such adverse influence on the majority of his fellows. Most of the common diseases are caused by two factors—

(1) an inherited constitutional weakness

(2) an unfavourable environment

in some cases the former, and in others the latter, is the more important. In very few is the in-born factor the sole cause.

Contact

Since the discovery of the Tubercle Bacillus, the importance of contact infection, particularly in childhood, has largely displaced the former hypothesis of Hereditary Diathesis. In more than 8 out of 10 infants dying from tuberculous meningitis, the source of infection can be traced to an open case of pulmonary tuberculosis in the family and in many families, in which there are several cases of pulmonary tuberculosis in brothers and sisters, there is evidence of massive childhood infection. With the fall in the number of open cases, infection of population becomes less universal, and those not infected in childhood run an increased chance of contracting pulmonary tuberculosis, if exposed to massive doses in early adult life.

Social Condition

Social conditions play a very impartant part in the incidence of pulmonary tuberculosis, the disease being much commoner in overcrowded areas. Any factor which leads to the congestion of population in a particular area, or causes a large number of people to live and work in close proximity to one another, increases the chances of massive infection—especially where the cubic capacity and ventilation are inadequate.

Nutrition is even more important to live—not merely to exist. Adequate nutrition is not a 'cure all' but it has been found and established that people with inadequate nourishment, with otherwise good living conditions, fall very readily to infection and recover rather slowly. It has been found that, where a congested area in a town has been cleared and where occupants have been transferred to a healthier spot in the suburbs, the health of that population tended to go down. That seems a paradox. "Fresh air, sun-light, clean open spaces" etc—the people now had. But now they had to pay heavier train and bus fares—consequently less money for food.

Nutrition

Considering the facts given above, the two main problems—in the prevention of tuberculosis are:—

1. Prevention of infection—which is most important in children and adolescents

and 2. Improvement of the general standard of health.

Prevention of Infection:—

1. Attempts to prevent tuberculosis *by "immunization" have* been made. The bovine strain *Bacille Calmette Guerin* was first introduced by Calmette in 1921, primarily for prophylatic treatment of new born infants in a tuberculous environment and has now been used for prophylactic purposes *in nearly half a million infants* all over the world. The best statistically controlled series is that of Kereszturi and Paul in New York who found the tuberculosis death rate among controls twice as high as among vaccinated infants. (B. C. G. is a preparation containing living tubercle Bacilli made avirulent by sub-culturing over a period of years.) The organisms in the vaccine *being alive,* the objection has been raised that they may revert to their former virulence in the body, but although this very occasionally happens in laboratory animals there is no record of its occurrence in man. In the Lubeck disaster, in which 77 children died, a virulent strain accidentally obtained access to the vaccine. B. C. G. *is extensively used in France. Prepared* according to the directions of Calmette it is quite safe. If given sub-cutaneously some 90 per cent of the infants are rendered allergic and react to the Mantoux test. If it is given by month only about 20 per cent show the reactions.

Immunization B. C. G.

Experiments on monkeys have proved that B. C. G. definitely confers some *immunity: it is not known how* long the protection lasts. Opinions differ as to the length of immunity conferred. In infants B. C. G. gives only relative immunity and does not protect against a large dose of infection. Experimental work on calves by Griffiths, Buxton and Glover, showed that immunity lasted 12 to 18 months and that revaccination did not give as good results as Primary Vaccination.

S. R. Rosenthal, advocated the multiple-puncture method of B. C. G. vaccination. L. Negre and J. Bretey of Pasteur Institute, Paris, experimented on guinea-pigs involving 30 to 50 punctures in two series and concluded that the method of multiple punctures was as efficacious as the vaccination subcutaneously or intradermally usually employed, in its prophylactic and sensitizing effects. Multiple scarification was as satisfactory as multiple punctures.

B. Weil-Halle, Director of the school of childwelfare of the Faculty of Medicine—pointed out, that during the 18 years employment of Calmette and Guerin's B C G, various forms of technique have been tried—oral, subcutaneous, intra-muscular and intradermal and that with out doubting the value of the others, preference had been given to the subcutaneous for its simplicity and efficacy in producing allergic sensitivity in 6 to 8 weeks, by a dose of 1-20 mgm A trial has been made in infants of Rosenthal's method, with slight modifications, especially the substitution of scarifications for punctures So far the results had been satisfactory and certainly free from any untoward effects in the scarified area but prolonged observation was obviously necessary with regard to the protective and immunising effects

2. *Early diagnosis of contacts and institution of preventive treatment:* Unsuspected cases are a great source of danger to others and it is regrettable that a considerable proportion of cases when first diagnosed have obviously been suffering from the disease for a long time D'Arcy Heart has called attention to the fact that radiological signs are present before symptoms have appeared and it is therefore useless to expect to make an early diagnosis if it is left to the patient to request an examination when he feels ill.

W. Ogden, with nine others outlines a method of tuberculosis control which has been practised at the Toronto Western Hospital Chest Clinic for 15 years It consists in—

1. A preliminary intra-cutaneous or Mantoux tuberculin test which if negative is repeated.
2. All patients giving positive results are subjected to serological tests (the tuberculo-complement-fixation and the Caulfield Inhibitive reaction)

When positive results are obtained, advice is given regarding—mode of living, diet, and rest These factors are regulated by the results of repeated serological tests. (The author states, that over a period of 15 years a total of 1300 known contacts and 400 normals, have been under observation and of those who have followed the prescribed *regime, not one has developed tuberculosis.)*

By means of these tests, contacts may be diagnosed and preventive treatment instituted months before diagnosis by physical signs, symptoms, or even by x-ray is possible The suggestion is even made, that the entire population could be controlled in this way commencing with semi-annual tuberculin tests at least, of selected groups of individuals,

Serial x-ray examinations of the whole population are obviously impracticable, at any rate at present, but there is much in favour of periodic serological and radiological examinations of selected groups of individuals, more likely than the average to contract tuberculosis Such groups would include—contacts of open cases, young nurses, children of elementary schools, medical students and diabetics.

Purity of Milk Supply

3. Milk - may be attributed to carry infection. As Bovine infection is entirely due to the use of tuberculous milk, it should not be difficult to eradicate the disease, either by pasteurisation or by the use of milk from tuberculin

tested herds In order to ensure certain standards of cleanliness and freedom from infective bacteria, milk has been graded and specified in the milk (Special Designation) order of 1936 in England, as follows ·

(i) "Tuberculin Tested Milk"—This must come from cows which have passed a Veterinary Examination and a tuberculin test and it must pass certain bacteriological tests for other organisms. The ministry order permits it to be described as 'Tuberculin Tested Milk (certified), when bottled on the farm it may be pasteurised and sold then under the title 'Tuberculin Tested Milk' (Pasteurised.)

(ii) Accredited Milk'—This is raw milk from the cows which receive Veterinary inspection but are not tuberculin tested. *It must also conform* with certain bacteriological standards with regard to the presence of other organisms.

(iii) 'Pasteurised Milk'—(Milk maintained at 145° to 150° F for half an hour.) Important point in connection with this pasteurisation is that the process should be carried out soon after milking and the container should not be opened until the milk is to be used Maximum time allowed for Pasteurisation and bottling shall be with in 8 hours of milking For infant feeding such a condition should be demanded

If raw milk is being used, it is clear the safest grade is 'Tuberculin Tested Milk' (certified) Despite its name 'Accredited Milk' is unsatisfactory for young children unless it is boiled.

Hygiene

4. To avoid the risk of massive infection especially in children and adolescents—with the human bacillus, the following hygienic measures have to be observed by the adult, with chronic pulmonary tuberculosis.

(i) The use of the sputum flask or

(ii) the use of paper handkerchiefs which are promptly burned

(iii) the holding of a handkerief in front of the month during coughing or *sneezing*

(iv) Fondling the children and kissing must be entirely forbidden,

In spite of these precautions children are usually infected when there is an open case in the house—especially where the cub c capacity and ventilation are inadequate Overcrowding should be eliminated, and all rooms must be kept clean and well ventilated, so that there is always a flow of 'Fresh air.' (Just recollect the instruction in Primers ' Don't sleep with the doors and windows closed. Don't sleep with face covered")

Instill into the minds of children, the importance of fresh air obtainable by keeping doors and windows open.

Sanatorium Treatment.

Sanatorium treatment—in which is included, the closure of cavities by collapse therapy in suitable cases, apart from the benefit to the patient, causes early disappearance of tubercle bacilli from the sputum, even in many patients who subsequently die of the disease, and therefore is of great value

in preventing spread of the disease But it is not possible to keep a large proportion of cases in institutions until sputum is negative.

In France, children are sometimes moved from an infected household and boarded out This method introduced by Grancher in 1903 and known as the Grancher system, has met with considerable success It does however deprive the child of the benefit of the home influence; so that if possible, it would be better to remove the infected patient Some local authorities have a scheme to board out the children when an open case returns home, for want of accommodation in the sanatorium.

Improvement and Maintenance of a General Standard of Health

The maintenance of general health is of particular importance—in the family contacts and in those heavily exposed to infection in the course of their work, e g Sanatorium nurses The individual's resistance must be maintained by —

(i) Adequate supply of good food— The provision by local authorities of extra nourishment to tuberculous patients and their families is an attempt to break the vicious circle by which the presence of pulmonary tuberculosis in the bread-winner so often reduces the money available for food, just at a time when the children need to be in a particularly good state of resistance to infection

Many a cheap food are of great value —so that mere poverty need not frighten us of malnutrition, e. g. Brown-bread, Pulses, Oatmeal etc, etc. On the other hand, many a rich man, does not automatically have the right kind of food but has bad diet resulting in very poor health, What is required then is some understanding of what kind of food gives best results A good diet roughly may be divided into 3 classes

(a) Energy-producing foods—as in Fats, starches and sugars Men who do heavy manual labour will need more of this than of any other section

(b). Food required for body building and repairing—are those that contain protein—found in meat, milk, eggs, cheese, fish, peas, beans, lentils Growing children will need almost as much as adults.

(c). Protective or protecting foods—Containing those mysterious, much abused, and much talked of vitamins drawn from dairy products, green vegetables and salads, and fruits and fat fish These help the body to make up for deficiencies, in the rest of the diet Nursing mothers, pregnant women, and young children, have a special need for this class of foods

(Vitamin A. Deficiency in Tuberculous patients :—H R. Getzetal used the bio-photo-meter to ascertain the presence of vitamin A deficiency in 500 non-tuberculous persons and 197 ambulant tuberculous patients Of the 500, 300 were used as control for the tuberculous group and were divided

into 2 groups, one of 229 medical students (mostly male,) and the other 71 junior women students The other 200 were not used as controls as they had a suspected deficiency

In the tuberculous group vitamin A deficiency was established in 53 per cent

In the two control groups medical students showed deficiency in 6 55 per cent and the junior women students in 11 27 per cent

It was stressed that the tuberculous group consisted of mild ambulant cases without fever and with minimal disease "It was apparent that the more advanced the disease the greater was the deficiency, but whether the advance of tuberculosis depends upon the deficiency or the deficiency results from the infection is yet unknown" The authors concluded, that the quantities of vitamin A required varied individually, and it was not possible to state an optimal amount for adults Apparently healthy subjects in this series showed a definite deficiency Large doses up to 200,000 units were necessary to obtain normal levels in deficiency and border-line cases in this study.)

(ii) Avoidance of strain and especially of excessive physical exertion.—Strenuous physical work weakens the resistance and this no doubt accounts for the fact that pulmonary tuberculosis is by no means uncommon among althletes. It is a mistake, though a common one, to regard the man trained to the utmost for a boat race or some other athletic effort as resistant to infection. He is probably more susceptible than the average city worker.

The resistance may be weakened by some accident or illness and thus allow a quiescent tuberculous lesion to burst into activity, but it is remarkable how rarely pulmonary tuberculosis follows an accident or illness.

(iii) By minimising the inhalation of dust especially—in those exposed, on account of their occupation Apart from Silica, dusts do not play an important part as predisposing factors in tuberculosis

"In spite of all measures, with all possible means, poverty and consequent malnutrition still remain potent factors in favouring the spread of tuberculosis'

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MANAGER.

A Case of Leprosy with Charcot's Joint

Dr. R. SUBRAMANIAM, B.SC., M.B.B.S.
*Honorary Assistant Physician to Dr. T. Satakopan, M.D.
Government General Hospital, Madras.*

Ramados, Hindu male, aged 30 was admitted in Dr. T. Satakopan's wards on 23rd November 1940. The presenting features of the case were main en griffe (claw hand) on the left hand and Charcot's joint of the left ankle and foot, with a perforating ulcer in the left heel.

Higher cerebral and mental functions normal.

No fits or abnormal movements.

Speech and articulations normal.

Cranial nerves normal excepting for anaesthesia over the depigmented patches on the face.

Sensory System: Subjective sensation normal.

Pain: Same as touch areas.

Temperature: Both heat and cold sensations appreciably affected in all four limbs. The loss of these sensations are absolute over the anaesthetic patches. This is best brought out over the anaesthetic patch on the left arm. Here the touch sensation is still retained.

Vibration sense absent in the left foot only.

Motor function: Drop foot present on the left side.

Muscular atrophy well-marked in left hand, left forearm and left foot. Slight but definite wasting of the right hand and fore-arm, and right foot also present.

Claw Hand with Anaesthetic patch on the Arm.

Charcot's Joint of the Left Ankle.

Touch: Impaired in all the extremities particularly at the extreme ends and also markedly impaired over the anaesthetic patches scattered over various parts of the body.

Reflexes; Abdominal, cremasteric, etc. present.

Flexor plantar response on the right side and no reflex could be elicited on the left side.

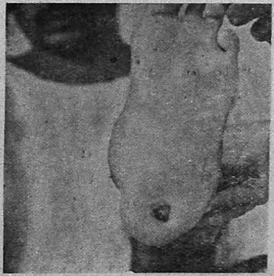
Jerks: Knee jerks brisk Ankle jerk retained on the right side. Could not be elicited on the left side. Biceps and triceps Jerks present.

Trophic lesions: Perforating ulcer over the left heel, showing the Calcaneous. Ulnar nerves thickened on both sides, particularly the right one. Peroneal nerves thickened, more the right one. Charcot's joint of the left ankle and foot.

Other systems nil abnormal. Urine: No sugar: No albumin. X-ray of the left foot: Rarefaction of all the bones with absorption. Well marked in the left fourth metatarsal and the navicular bones.

X-ray of the spines nil : abnormal.

Discussion: Leprosy: The main features of the case being one of leprosy are



Perforating Ulcer Sole of the Left Foot.

(1) Anaesthetic patches.

(2) Thickening of the ulnar nerves and superficial peroneal nerves. The thickening of the nerves on the right side the side, which is less affected, and is free from anaesthetic patches is due to the fact that the nerve in the right side is still in an inflammatory condition whereas on the left side it has gone on to fibrosis and so it is smaller in calibre.

(3) Perforating ulcer on the sole of the foot.

(4) Skiagram of the foot showing absorption of the metatarsal bones so that the whole foot characteristically gets smaller. The long duration of the disease is probably to be attributed to the fact that the patient has been continuously under treatment for the last seven years.

The case could be clinched as one of leprosy by demonstating the Lepra bacilli by a clipping from one of the nerve sheaths of a thickened nerve.

Syringomyelia: Superficially the case may be mistaken as one of Syringomyelia due to the presence ot the Charcot's joint, claw-hand and dissociation of anaesthesia. The points of differentiation are, no one isolated lesion in any part of the spinal cord can give such areas of dissociation of sensation, as also the presence of the thickening of the ulnar and peroneal nerves and depigmented patches. X-ray of the spine does not show any abnormality, as in most cases of syringomyelia there is some abnormality as spina-bifida etc.

Tabes Dorsalis: Charcot's joint and the perforating ulcer of the sole of the foot are lesions in favour of the case being one of Tabes but the features of Tabes such as, the characteristic pains, as pins and needles, pupillary changes as Argyll Robertson's pupils, absence of knee and ankle jerks are absent in this case. Blood Wassermann reaction is of no avail as it is positive in both leprosy and syphilis.

Peculiarities to be noted are: The long course of the illness as over seven years, and the treatment the patient had all these years making it difficult of recognising the malady

Charcot's joint in a case of leprosy.

Knee jerks brisk inspite of the advanced condition of the neuritis. Treatment advised in this case was on conservative line namely, glycerine mag-sulph packing to the affected leg to reduce the swelling and to continue with the treatment of leprosy in the hope that the disease may be arrested at the present stage at least

My thanks are due to Dr. T Satakopan and to the Superintendent, Government General Hospital, Madras, for their kind permission to report this case,

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How to Stagnate in Medicine.

There are several rules which must be kept in mind, if we wish to deteriorate in medical skill and knowledge.

The first rule: File your patient's records away and forget all about them. Never go over them after the day's work is done and try to pick out errors of omission or commission; never try to follow up patients to learn whether your diagnosis was correct and if your treatment helped the patient Best of all, keep only a few scribbled lines about each case, preferably without making any attempt at a diagnosis

The second rule: Read medical books and magazines with an eye only for the "practical"—that which can be used at once Skip over the physiology, pathology, and differential diagnosis, so that you can concentrate on treatment Read the summaries at the end of articles; only a sucker will dig through the article itself. Best of all never refer to standard texts, but be content to skim off a few novelties from the medical journals

The third rule: Never take a chance of confirming your diagnosis by consultation with a specialist (unless, of course, an unreasonable patient insists on it and you can't snub the bounder) or by necropsy Thus you can cheerfully go ahead making the same mistakes over and over Most people don't know the difference, anyway

By following these basic precepts and by avoiding postgraduate courses and medical meetings, you may be assured of a comparatively rapid and certainly unlaborious, decadence.—*Clin Med. and Surg.*

Abstracts and Notes

TREATMENT OF CONJUNCTIVITIS

B. R. Medlycott: *Practitioner*. May 1940

In infective conjunctivitis, prophylaxis is of the utmost importance for the protection of contacts and the prevention of infection spreading to the good eye in the unilateral type. Scrupulous care must be taken of cotton wool, handkerchiefs, towels, and the hands, and the good eye should be protected by a Buller's shield.

Irrigation should be instituted directly infection is suspected, the most effective method being by means of an undine, or failing this, pledgets of cotton-wool soaked in the solution. Bland lotions are the best, such as normal saline (0'9 per cent NaCl), 1'4 per cent NaCl, boracic acid 8 grains to 1 ounce, or sodium bicarbonate 10 grains to 1 ounce. Useful antiseptic solutions are mercury oxycyanide (1 in 10,000) and mercury perchloride (1 in 10,000). The patient should be in the recumbent position with a mackintosh under the head and a kidney dish to the cheek. Adherent discharge is removed with moist swabs. Bandaging is contra-indicated as the irritating discharge injures the corneal epithelium and bacterial growth is increased by warmth. Treatment should be carried out three times daily in mild cases and and at one to two hourly intervals in severe gonococcal ophthalmia. Silver nitrate in the form of drops is not used except in a 1 per cent solution for the treatment of ophthalmia neonatorum, but painting of the lids with a 2 per cent solution shortens the course of the disease if done in the early acute stage. Frequent application of silver nitrate is contra-indicated except in chronic cases, but eye drops of Argyrol 10 to 20 per cent, or Protargol 10 per cent can be employed after irrigation in the early stage. This treatment must not be continued for more than one month.

For the prevention of adherence of discharge to the lids and eyelashes soft yellow paraffin, either alone or combined with boracic acid 30 grains to 1 ounce, is useful, and relief of the oedema is obtained by application of ice-cold swabs. Dark glasses add to the patient's comfort if photophobia or blepharospasm are present.

During the stage of resolution zinc sulphate or zinc chloride drops, (1 grain to 1 ounce) twice or thrice daily, can be used, and the conjunctiva can be massaged at bed time with an ointment such as ichthyol 8 grains, zinc oxide 4 grains, and soft yellow paraffin 1 ounce. After the acute stage has passed, irrigation is reduced to 2 or 3 times daily, and an astringent lotion can be employed, such as lotio aluminis (alum purificatus 4 to 6 grains to the ounce).

TREATMENT OF MENINGOCOCCAL MENINGITIS

Harries. *Lancet* March 16, 1940.

The author has studied the first 100 cases admitted to the City Isolation Hospital, Cardiff, since the beginning of this year. The ages ranged from 5 months to 70 years. There was a slight preponderance of females over males. There were 8 deaths. One case was purely meningococcal septicaemia, the cerebrospinal fluid being normal and no changes in the nervous system be-

ing found post mortem, apart from slight meningeal congestion; a few cubic centimetres of blood taken during life and haemolysed with dilute acetic acid showed gram-negative diplococci in a centrifugalised deposit. The cases generally were more severe than the sporadic cases in previous years, and the later more so than the earlier.

Treatment consisted of 4 tablets of M and B 693 by mouth on admission repeated in 4 hours time, and then 2 tablets 4 hourly for 72 hours. Then, provided the sugar content of the cerebrospinal fluid was approaching normality, the dosage was reduced to one tablet 6 hourly for 24 hours, and then one tablet t. d. s. for a further 3 or 4 days. Children under 12 years received half the adult dosage, irrespective of the age of the child, as even infants appear to tolerate the drug quite well. Lumbar punctures were performed daily until the sugar content of the cerebrospinal fluid was satisfactory, and no case was considered out of danger if the sugar had not returned. If the patient was comatose the tablets were crushed and given in nasal feeds. If vomiting occurred after ingestion of M & B 693, or the patient was delirious and nasal feeding was difficult, the sodium salt of M & B 693 was given by intramuscular injections. In severe cases the sodium salt of M & B 693 was given intravenously in about ½ to 1 litre of normal saline by the drip method. It was generally unnecessary to cut down on a vein for this purpose. No serum was given intrathecally, but 30 to 60 c. c. of meningococcal antitoxin were given intravenously in normal saline in severe cases. Fluids were pushed in all cases, as dehydration can contribute materially towards the fatal issue, and two patients who ultimately recovered after being in coma for 5 to 7 days were given fluids by nasal feeds at 4 hourly intervals.

Owing to the fact that extensive haemorrhages are not infrequently found in the adrenals, cortical extract was given in the fulminating cases intramuscularly, salines were given rectally in severe toxic cases, and in a few instances, intravenously, as sodium chloride is advocated in cases of adrenal damage. One child whose pulse was imperceptible on admission made a complete recovery when treated on these lines. Petechiae were present in about a third of the cases, and facial herpes as well as petechiae in about a sixth of the cases (Complications were rare. Four cases developed arthritis, two iritis, three bilateral nerve deafness, and one, orchitis. Complete recoveries from these complications were made upon renewal of large doses of M & B 693, with the exception of the cases of nerve deafness).

INDICATIONS FOR ULTRA-VIOLET THERAPY.

Minnesota Medicine says that ultra-violet irradiation has been recommended for such a large variety of diseases that it is absurd to imagine that this agent is really of value in them all. However there are a few diseases where the use of ultra-violet radiation is scientifically correct and a number more where its use is supported by enough clinical evidence to be impressive.

Rickets, *infantile tetany or spasmophilia*, and osteomalacia: In these conditions the well proved ultra-violet effect upon calcium metabolism makes its use rational.

Tuberculosis: *Most authorities agree* that ultra-violet radiation is useful as an adjunct to the usual treatment (rest, food, etc) in extra-pulmonary tuberculosis This includes tuberculosis of the bones or joints, of the lymph glands, of the peritoneum and intestines, and of the genito-urinary system In some selected forms of chronic pulmonary tuberculosis many workers think that ultra-violet therapy is indicated, while others believe that it is contra-indicated in all forms of pulmonary tuberculosis

Erysipelas · Ultra violet irradiation is the treatment of choice, in the author's opinion, and he has obtained very satisfactory results in more than 500 cases The mode of action is not yet understood Heavy doses of ultraviolet rays should be given in the treatment of erysipelas, from 6 to 20 erythema doses

Certain skin diseases are treated by ultra-violet, such as lupus vulgaris, scrofuloderma, pityriasis rosea, psoriasis, acne vulgaris, adenoma sebaceum, erythema induratum, and alopecia areata

Indolent ulcers and wounds in general are helped towards cure by ultra-violet rays. Small doses are used in the treatment of chronic draining sinuses and decubitus ulcers,

Following extensive burns, the healing period may be greatly shortened by the use of ultra-violet radiation.

Tonic effect: In many chronic diseases where malnutrition or deprivation of sunlight is a factor, the use of ultra-violet radiation is indicated for its tonic and psychologic as well as anti-anaemic effects. In this group may be included sufferers from arthritis of any type, *paralysis, multiple sclerosis, neurasthenia*, hemiplegia, and many other chronic conditions

*Contra-indications: The use of ultra-*violet radiation is contra-indicated in active and progressive forms of pulmonary tuberculosis, hyperthyroidism, diabetes, highly nervous people, advanced cachexia and inanition, and aged people with acute or chronic nephritis or myocarditis It is *also* contra-indicated in certain skin diseases such as all forms of generalised dermatitis, lupus erythematosus, herpes simplex, erythema solare perstans xeroderma pigmentosum, hydroaestivale, freckles, keratoses, and prematurely senile skin

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URETHRAL CALCULUS.

W G Schulte · *Rocky Mountain Medical Journal.* May 1940

Calculi lodged in the urethra are rarely encountered Joly divided urethral calculi into two groups; those which develop in the urethra he called autochthonous or primary, and those which have their origin in the upper urinary tract were classed as migratory or secondary The latter are encountered about eleven times as frequently as the former Urethral calculi are more frequent in the anterior urethra than in the posterior Primary calculi are phosphatic, while secondary calculi are composed of all the constituents of urinary incrustations

Inflammatory changes are always present with urethral stones There may be dilatation proximal to the calculus. Primary calculi develop as a result of stagnation and infection of

poorly drained cavities. Commonly following prostatic or periurethral abscess, urethral diverticulum, incrustation of ulcers, tears of the urethra, or foreign bodies in the canal Urethral strictures are probably not a factor in the formation of autochthonous, but they may be very important in obstructing migratory stones. It is sometimes difficult to state whether a urethral calculus is primary or secondary Migratory calculi are single, very rarely multiple, most frequent in males Primary stones are usually multiple and larger in size. Primary stones are often symptomless for a long time Secondary stones produce sudden obstruction, partial or complete There may be dribbling and hesitation, with some relief following manipulation of the stone Palpation of the urethra often discloses the presence of a foreign body; instrumentation produces a grating sensation as the calculus is encountered Roentgenography is invaluable in diagnosis.

Urethral calculi have been encountered in the bulb of the urethra in the scrotal and penile portions of the urethra, and in the fossa navicularis The largest urethral stone on record is one reported by Swift Joly which weighed 2¼ pounds.

Journal of South Indian Medicine

NOTICE

CONTRIBUTIONS of medical interest—original articles, case notes, clinical memoranda—are invited. They should be addressed to the PUBLICITY OFFICER, JOURNAL OF SOUTH INDIAN MEDICINE, 56, Thambu Chetty Street, Madras and should be accompanied by a stamped addressed envolope if their return is desired in case of non-publication.

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MANUSCRIPTS must be written clearly or preferably type-written, with double spacing, on one side of the paper only

Books and pamphlets for review should be sent to the Publicity Officer who will be pleased to receive also reprints of which abstracts will be of interest to the profession Journals for exchange or review should be addressed to the Publicity Officer

JOURNAL OF SOUTH INDIAN MEDICINE

JANUARY 1941

New Year Thoughts.

We wish all our readers a happy New Year! Few can be found sorry to have seen the last of a year that brought so much misfortune to such large parts of the world. Let us start the New Year on a note of hope of better things to come!

Looking back at ourselves, it is a matter for gratification that we have become stronger in numbers and spirit But that should be, not an inhibitor but an ever-increasing stimulus to us to go one better this year, and show a wider and still stronger Union next year It is to be devoutly hoped that members of the independent medical profession will assimilate the lessons of recent history re the smaller "neutrals" and realise that only early and concerted action on their part can save them from the "benefits" of "New orders" Economic strangle-holds are again to shackle them in the form of several new orders and only an early realisation of this and prompt action by all of us can prevent this Onwards then with a new drive for membership and a new zest for work!

The quotation "The evil that men do lives after them, the good is oft interred with their bones," seems to be singularly true regarding the Congress Ministry in Madras They upset the whole Honorary system of the past and walked out before evolving a new one Scores of concientious Honorary Medical Officers who had given of their best to the Hospitals of the Presidency for years, have been put out And now comes the rumour that the present incumbents are to hold charge indefinitely, especially in the higher ranks! Rather hard on the "outs"! Looks like "I don't like you, Dr. Fell" business on them!

Another suggestion is that many posts and honorary officers do not fit, that is either the officers are not suitable or they are not available, We did hear the same argument in the case of the appointment of Indians to expert posts in the recent Industry drive in the country—and a similar argument that aeroplanes, cars and ships are hard to manufacture in India, though ammunitions are easily made here in large quantities. All we can say is that there is a strong family resemblance between these excuse brothers—and they may all die equally quickly in the face of reality and urgent necessity.

Rather surprising also that in the face of the acute necessity for economy and the lack of any suitable reasons, many Honorary posts are going to be

converted to be paid We are awaiting fuller particulars before proceeding to show up the patent dishonesty of talking of expansion of the Honorary system in the light of such changes.

One good the Congress Ministry did; and that we hear is now on the way to be interred or interned with them. That is the rule about the service men and private practice Obviously the powers that be believe in the quotation "For unto him that hath shall be given and he shall have abundance; but from him that hath not shall be taken away even that which he hath." If the 5000 and odd private practitioners are to go from bad to worse, or more hopefully, from good to less good due to this new found freedom of the service men to go back to their practice, their insurance work and their certificate work, well, that is their look out. The Government must look after its servants small as they are in number They must not lack even a few calories, the private practitioners can go without—food! And to think that Dr Rajan advised the practitioners not to have the mentality of a Trade Union! It is a funny world.

THE MEDICAL ORGANISATION YOU NEED AND TO WHICH YOU SHOULD BELONG.

The General Secretary,

SOUTH INDIAN MEDICAL UNION,

Ritherdon Road, Vepery, Madras.

Dear Sir,

I desire to become a member of the South Indian Medical Union, and request you to place this application before the Governing Body

I am, yours truly,

Membership Fee :

Madras Rs. 6 per annum,

Mofussil Rs. 3

*Name*____________________

*Address*____________________

Please detach and post

Jottings

1. We all did know that sooner or later Astrology would come into its own But we never thought that it would intrude into fields not its own. There is much to be said in favour of its inclusion in the case sheets, e.g. the surgeon who is asked by his colleague as to what the Post mortem revealed in a recent fatal operation would just say "Oh, no Post mortem was necessary, that malific Rahu in the 8th house with an angry Mars had made it a foregone conclusion that he should die as a result of the operation" In fact it will serve as a very useful alibi for many things Our only regret is that its able exponent did not put this into practice when he was in the hospital, or did he?

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2. About this new label we seems to be getting recently—Allopaths—we must honestly say that we do not like it. There is an atmosphere about it of some particular fad in treatment The "pathies" may come and "pathies" will go, but scientific medicine will definitely stay If any of us want a label we would like to point out that the correct one is scientific medicine. The only surprise is that even the great among us talk of ourselves as Allopaths as distinct from other paths and pathies.

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3. We claim to be second to none in our love and admiration of things Indian. But that won't justify us in sticking to the bullock cart because that was the vehicle of our ancients. Similarly there is no sense in sticking to the few remnants of Ayurvedic system handed on to us, and claiming that that is the last word in medical wisdom for all time to come. Ayurveda might well say "save me from my friends" if such misguided attempts only succeed in holding up its further advances by this claim to be the one and only revelation. China and Japan, Egypt and America had all their own Ancient medicines but we don't find them sitting on the top of it and claiming to have reached the sky

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4. We heartily congratulate Dr. K S. Ray on his interesting presidential address at the All India Medical Conference at Vizag. His suggestions regarding the creation of some type of National Health Insurance are worthy of earnest attention at the hands of the authorities as well as the Medical Profession.

Reviews of Reports.

1. ADMINISTRATION REPORT OF THE KING EDWARD VII MEMORIAL HOSPITAL, AND THE SETH GORDHANDAS SUNDERDAS MEDICAL COLLEGE, BOMBAY FOR THE YEAR 1939-40.

This report is intresting as showing the excellent management of both a hospital and a college by Honorary Medical Officers (except for a few full time officers for purely nonclinical subjects like Anatomy, Physiology etc) Needless to say, fortunately for the institution, no bright intellect there, seems to have thought of a five year's term for the Honorary Officers. We hope the authorities here will peruse this report and learn the obvious moral.

2 ANNUAL REPORT ON THE HEALTH OF THE ARMY IN INDIA FOR THE YEAR 1939, VOL. II PART I.

This report on the health of the Army in India is very interesting and instructive. Taking some of the points mentioned, one of them specially educative to us, is the confirmation in the army of the wide usefulness of the Sulfapyridine group of drugs The fall of W B C after its use is mentioned, and a count below 6000 before treatment and a count below 5000 during treatment are given as contra-indications. A case is also mentioned where sulphonamide was found to be of little therapeutic effect in Gonorrhea when the patient was sunbathing at the time; when the sunbathing was stopped the full therapeutic effect became manifest. Sulphonamide P. was found to be of great use in shortening the average stay in hospital for Chancroid cases from 31 to 16 days.

In Gonorrhea a routine method of treatment has now been adopted; the principle being to adopt a high concentration of the drug in the body as soon as possible and discontinue before toxic symptoms have developed. Thus 28 gms over 4 days is one routine method with no local treatment and on ordinary diet.

There are occasionally viens of unintentional humour as for instance "the gentleman who offered to cure all malaria with a special medicine which on examination proved to be nothing but common salt!"

The report on special subjects at the end of the volume indicate the great amount of medical work, preventive and curative, which is carried out by the Military Medical Services for the Army in India. A close study of this report with its wealth of useful information, is well worth the time spent on it.